TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Doctors Hospital at Renaissance

Respondent Name
Texas Municipal League Intergovernmental Risk Pool

MFDR Tracking Number
M4-17-3404-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 21, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to TWCC guidelines, Rule §134.403 states that reimbursement calculation used for establishing the MAR shall be by applying the Medicare facility specific amount."

Amount in Dispute: $1,827.57

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Subject to further review, the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines".

Respondent's Submitted By: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 13, 2016	Outpatient Hospital Services	$1,827.57	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.

– The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - P12 – Workers' compensation jurisdictional fee schedule adjustment
  - 193 – Additional payment made on appeal/recon
  - W3 – Additional payment made on appeal/reconsideration

Issues

1. What is the Medicare payment rule?
2. What is the applicable rule that pertains to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking $1,827.57 for Codes 26765 –F2 and 26765 –F3, "Open treatment of distal phalangeal fracture, finger or thumb, includes internal fixation, when performed, each," rendered on December 13, 2016.

   The requestor states in pertinent part, "After reviewing the account we have concluded that reimbursement received was inaccurate." The respondent states, "…the carrier asserts that it has paid according to applicable fee guidelines…" Therefore, the services in dispute will be reviewed per applicable Rules and Fee Guidelines discussed below.

2. The relevant portions of 28 Texas Administrative Code 134.403 are:

   (b) Definitions for words and terms, when used in this section, shall have the following meanings, unless clearly indicated otherwise

   (3) "Medicare payment policy" means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.

   (d) For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section, including the following paragraphs.

   (f) The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:

   (A) 200 percent; unless

   (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent

Review of the submitted medical claim finds separate reimbursement for implantables was not requested.

The Medicare facility specific amount of the services in dispute is calculated as follows:

- Procedure code 26765 –F2 has status indicator T. Per the Medicare Claims Processing Manual, Chapter 4 - Part B Hospital, Section 10.1.1 - Payment Status Indicators, at www.cms.gov,

  Services with status indicator T are paid separately under OPPS but a multiple procedure payment reduction applies when two or more services with a status indicator of T are billed on the same date of service.

Based on the above, this procedure is paid at 100% and is assigned APC 5121. The OPPS Addendum A rate is $1,455.26. This is multiplied by 60% for an unadjusted labor-related amount of $873.16, which is multiplied by the facility wage index of 0.8026 for an adjusted labor amount of $700.80. The non-labor related portion is 40% of the APC rate, or $582.10. The sum of the labor and non-labor portions is $1,282.90 multiplied by 200% for a MAR of $2,565.80.

- Procedure code 26765 –F3 has status indicator T and will be paid at 50%. The total Medicare facility specific amount, including multiple-procedure reduction, equals $641.45 multiplied by 200% for a MAR of $1,282.90.

3. The total recommended reimbursement for the disputed services is $3,848.70. The insurance carrier has paid $4,365.78 leaving an amount due to the requestor of $0.00. Additional payment is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		August 17, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.